Active duty

If you are called to active duty and are benefits eligible at the start of your Military leave, you will retain benefits eligibility while on Military leave.

Impact to your benefits

Your Starbucks coverage will continue as outlined below:

- **Medical, dental and vision:** Length of coverage continuation depends on your length of service with Starbucks. Continuation of active health coverage will reduce your 24 months of available COBRA continuation. If you return to work after coverage has ended, coverage may be reinstated upon your return.
  - » *If you have been employed less than six months from your most recent hire date,* your active coverage will continue through the end of the month in which your leave exceeds 52 weeks provided you continue to pay your contributions.
  - » *If you have been employed six months or longer from your most recent hire date,* your active coverage will continue through the end of the month in which your leave exceeds 78 weeks provided you continue to pay your contributions.
- **Partner and dependent life insurance, accidental death and dismemberment and disability coverage:** Continues through the 12th month of leave provided you continue to pay your premiums. When coverage ends, you may elect to continue coverage through conversion or portability options. See the Life Insurance chapter for more information.
- **Dependent care reimbursement account:** Participation is suspended effective the start of your leave. Participation is reinstated upon your return to work unless you return in a new plan year.
- **Health care reimbursement account:** While on an approved Military leave, you have the option to continue making your contributions for the remainder of the plan year and retain your full annual election. Otherwise, participation is suspended effective the start of your leave. Your annual election is reduced by the amount of your missed contributions and expenses incurred during your leave are not eligible for reimbursement. Participation is reinstated upon return to work unless you return in a new plan year. Contact Starbucks Benefits Center Leave Administration at (877) SBUXBEN to continue your participation.
- **Employee Assistance Program:** Benefit continues during your active duty Military leave.
- **Adoption assistance, tuition reimbursement:** Benefit continues during your active duty Military leave while considered benefits eligible.
- **Partner markout and discount:** Benefits continue during your Military leave.

You have 45 days from the start of Starbucks Military leave to request cancellation of your Starbucks coverage. You can re-enroll in coverage upon your return from an approved Military leave and must do so within 45 days of your return. Contact Starbucks Benefits Center at (877) SBUXBEN to make changes to your benefit elections.

Upon return to work from an approved Military leave, your benefits eligibility will be reinstated. You will not be subject to an ongoing benefits eligibility audit until you have returned for one full calendar quarter (for mainland partners) or one month (for Hawaii partners). Refer to "Ongoing benefits eligibility" on page 11 for more information.

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If coverage ends while on leave of absence

Generally, coverage that ends during your leave of absence will be reinstated the first of the month following your return to work from an approved leave of absence. Following a Military leave, coverage reinstates on the day you return to work. The exception is when you take a Personal leave and your coverage ended as a result of an ongoing eligibility audit.

Payroll contributions missed while on leave of absence

If, due to your leave, your normal payroll deductions are not taken, you will be required to make up the cost of coverage for any missed deductions in order to continue your benefits coverage. See "Missed payroll deductions" on page 22 for more information.

Compassionate Benefits for Terminally Ill Partners

Being diagnosed with a terminal illness can be devastating emotionally as well as financially. To alleviate the financial burden of the cost of health coverage and life insurance for a benefits-eligible partner diagnosed with a terminal illness, Starbucks provides special assistance.

If, while you are employed with Starbucks, you are diagnosed as terminally ill (life expectancy of 24 months or less) and you become disabled, you are eligible for two unique benefits:

- Continued life insurance coverage and a waiver of life insurance premiums
- After employment ends, continued health coverage through COBRA for you and your enrolled dependents, if any, fully paid by Starbucks for a period of time after employment ends

Continued life insurance

Your employment status will be deemed to be continued for the minimum period of time required to establish eligibility for waiver of premium under the Hartford Life and Accident Insurance Company contract, typically six months following the date your disability began. Refer to the Life Insurance chapter for more information about life coverage continuation and waiver of premium.

Health coverage continuation

If your health coverage benefits terminate while you are still employed, you may elect to continue your health coverage for yourself and any enrolled dependents through COBRA. If you elect COBRA continuation, Starbucks will pay the difference between the COBRA cost and your active coverage contribution. Upon termination of employment, Starbucks will pay the full cost of COBRA coverage you have elected until your COBRA coverage period expires, you become eligible for Medicare or your death, whichever occurs first. For three months following your death, Starbucks will pay for the cost of continued COBRA coverage for your enrolled dependents. If, however, COBRA coverage would have terminated because you/your dependents reached the maximum COBRA continuation coverage period, then coverage will end when COBRA expires.

To be eligible for Starbucks-paid COBRA coverage, you must have fully paid your coverage contributions through your termination of employment.

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For Partners Working in Massachusetts

In accordance with Massachusetts state law, Starbucks is providing eligible partners working in the state of Massachusetts the opportunity to purchase medical coverage through the Massachusetts Health Connector on a before-tax basis. If Massachusetts partners elect to pay for medical coverage premiums, their regular compensation will be reduced on a before-tax basis by the amount of the premium payment for the coverage selected. This medical coverage is not offered through the Starbucks Corporation Welfare Benefits Plan (as described in this U.S. Benefits Plan Description), is not endorsed by Starbucks and is not part of the Starbucks benefit program. Additionally, although the Connector has granted its seal of approval to these medical coverage options, coverage is provided by the insurance carrier issuing the applicable medical insurance policy. Neither the Connector nor Starbucks has any liability for any benefits due, or alleged to be due, under any such medical insurance policies.

To be eligible to use before-tax dollars to purchase medical coverage under the Massachusetts Health Connector, a partner:

- Must be working for Starbucks or a participating company (i.e., a company that is wholly or partially owned by Starbucks and has elected to participate in the Plan), and
- Be working for such company in the state of Massachusetts (whether or not you are a Massachusetts resident).

A partner is not eligible for benefits under the Massachusetts Addendum if they are:

- Eligible to participate in Starbucks benefits as described in this Eligibility and Enrollment chapter
- Less than 18 years old
- Covered by a collective bargaining agreement if health benefits were the subject of good faith bargaining
- A temporary employee
- Regularly scheduled to work fewer than 64 hours per month
- Wait staff, a service employee or a service bartender earning less than $400 in monthly payroll wages
- A student employee employed as an intern or a cooperative education student worker, or
- A seasonal employee who is an international worker with either a U.S. J-1 student visa or a U.S. H2B visa and have travel health insurance.

Partners eligible for benefits under this Massachusetts Health Connector who wish to use before-tax dollars to pay for medical coverage offered through the Connector must complete and sign a salary reduction agreement electing to reduce their regular compensation to cover the cost of such coverage within 30 days following the date they become eligible. They will also need to select a medical plan and complete an enrollment form through the Connector. For more information on medical coverage options offered through the Connector and/or to enroll in medical coverage, visit the Connector's website at www.MAhealthconnector.org.

In general, all elections under the Massachusetts Health Connector are irrevocable during the plan year (October 1 through September 30). Elections become effective on the first day of the month following the month in which an election is made. If a qualified status change occurs during the plan year, changes may be made as described in "Making Changes" on page 24.

Partners eligible for benefits under the Massachusetts Health Connector that decide not to use before-tax dollars to pay for medical coverage, or do not enroll in medical coverage within 30 days following the date they become

eligible, will be deemed to have elected cash in lieu of such coverage. This means that, absent a qualified status change, they will not be able to use before-tax dollars to purchase medical coverage until the next annual benefits open enrollment period.

Before the start of each plan year, Massachusetts partners will be offered the opportunity to change their existing election during an annual benefits open enrollment period. If they do not make a new election, the existing election will remain in effect.

Cost of benefits

Massachusetts partners are required to pay the entire cost of any coverage they elect under this Massachusetts Health Connector. Starbucks has no responsibility to cover, pay or advance any amount.

The maximum amount of elective contributions under the Massachusetts Health Connector is the total cost for the plan year of the most expensive medical coverage option available that has been granted the seal of approval by the Connector.

Description of benefits

Partners may use before-tax dollars to purchase any medical coverage that has been granted the seal of approval by the Connector. No other benefits are offered under the Massachusetts Health Connector. For more information on medical coverage options offered through the Connector and/or to enroll in medical coverage, visit the Connector's website at www.MAhealthconnector.org.

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When Your Employment Ends

The following chart outlines what happens when your employment at Starbucks ends. You will also find how your loss of eligibility affects your benefits coverage within each individual chapter of this guide.

BENEFIT	IMPACT
Medical, dental and vision coverage	Coverage ends on the last day of the month in which your separation is processed by payroll. You may elect to continue your coverage under COBRA, unless you have been terminated due to gross misconduct. For more information about COBRA, see the Your Rights and Responsibilities chapter.
Dependent care reimbursement account *(salaried and nonretail hourly partners only)*	Your participation ends as of your final contribution.
Health care reimbursement account *(salaried and nonretail hourly partners only)*	Your participation ends as of your final contribution. If you have amounts remaining in your account, you may elect to continue your participation through the end of the plan year in which you participate on an after-tax basis through COBRA. For more information about COBRA, see the Your Rights and Responsibilities chapter.

BENEFIT	IMPACT
Short-term and long-term disability	Coverage ends on the last day you are actively at work at Starbucks. If you have been approved for disability benefits prior to your last day worked, your disability benefits will continue according to plan provisions.
Life insurance	Coverage ends on the last day you are actively at work at Starbucks. You have 31 days from the date you separate to convert your Starbucks paid life insurance to an individual policy, and to convert or port your supplemental life coverage. If you are permanently and totally disabled and have received a waiver of premium, your life insurance coverage continues at no cost to you.
Accidental death and dismemberment	Coverage ends on the last day you are actively at work at Starbucks.
Employee Assistance Program	Coverage ends on the last day of the month following the month in which your separation is processed by payroll. You may elect to continue this benefit by electing to continue your Starbucks medical coverage through COBRA. For more information about COBRA, see the Your Rights and Responsibilities chapter.
Adoption assistance	Your eligibility to apply for reimbursement ends on the last day you are actively at work at Starbucks. If you are planning to leave Starbucks and you have eligible expenses that were incurred while working at Starbucks, you must file your request for reimbursement before you terminate employment.
Tuition reimbursement	Benefit ends on the last day you are actively at work at Starbucks. You must be actively employed at the time your reimbursement is processed by payroll to be eligible to receive a benefit from the plan.
Markout and discount	Ends on the last day you are actively at work at Starbucks.

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Employee Assistance Program (EAP)

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The Employee Assistance Program (EAP) can help you with confidential personalized care including:

- Short-term counseling for stress-related issues, emotional difficulties, critical incidents in the workplace, alcohol and drug abuse, concerns at work or at home, family and relationship issues, parent/child concerns and most other personal concerns
- A full range of dependent care resources, from finding appropriate child and elder care resources, to locating summer camps or researching financial assistance for college
- Legal consultation and discounts on continuing legal consultation services
- Financial consultation

The EAP offers telephone consultation and referral services, face-to-face counseling, Web-based self assessment, information and resources to help make life more manageable.

EAP coverage is available to all U.S. partners, even when traveling abroad. You do not have to do anything to be eligible for the EAP — you and your family members may simply call the EAP at (800) 327-5564 when you need it. It is available 24 hours a day, seven days a week. You may also link to the EAP from www.mysbuxben.com.

How the Plan Works

The EAP is administered by Magellan Health Services. When you call, you will speak with a Magellan clinician who will work with you to identify your needs and determine the course of action best suited to your situation, or direct you to services that may help you.

For counseling services, you may be referred to a counselor who is generally no more than a 30-minute drive from your home or work. In the case of an emergency, the EAP will refer you to the nearest appropriate resource.

What to expect when you call

When you call the EAP, here is what you can expect:

- You will immediately speak with a counselor who will ask for some personal information — your name, address, phone number and other information as necessary.
- The counselor will ask you some basic questions to help identify why you are calling and determine how the EAP may help.
- Then, depending on your needs, you could be transferred to a specialist on the life management team, or a lawyer or financial specialist. In addition, you can always take advantage of up to three face-to-face visits with a local provider and you will be given names of providers to choose from. An EAP representative can also help make the appointment, if you prefer.

Confidentiality

The EAP is a confidential program. When you call the EAP, your contact with the program will not be revealed to anyone — including Starbucks — without your permission, except as required by law. You and your enrolled dependents' records are kept by the EAP and are not part of your Starbucks partner file.

What the Plan Covers

The EAP acts as an assessment, consultation and referral service for a large number of personal issues.

Short-term counseling visits

Visits 1–3

You and your enrolled dependents may receive from one to three visits per six-month period when referred to an EAP counselor. To be covered by the EAP, you must visit the counselor to whom you are referred by the EAP. Otherwise, your counseling is not covered.

More than three visits

If you need more than three visits for mental health or chemical dependency care or if you need a type of care outside of EAP counseling and are enrolled in a Starbucks medical plan, you may be covered. If you are enrolled in HMSA, Kaiser California HMO or Kaiser Hawaii HMO, refer to your health provider's guide to benefits for information regarding mental health/chemical dependency benefits.

Your EAP counselor may recommend continued care be provided by a specialized provider, in which case Magellan may help you locate a network provider.

Resource and referral services

The EAP provides resource and referral services that can connect you to the information and services that may help make life a little more manageable. This includes referrals to resources for services such as child care, elder care, help for everyday needs and much more.

You may receive free and confidential services throughout the United States and while traveling abroad 24 hours a day, seven days a week, including holidays. If you need a translator or TDD services, these are also available at any time.

Specific services offered to help you lead a more satisfying, less stressful life include, but are not limited to:

Adult/elder services

Contact the EAP for information on elder care, Medicare, Medicaid, estate planning, special nursing care and the aging process for assistance in taking better care of elderly parents and adult dependents.

Child/family services

You may use the EAP to obtain quick answers on topics like parenting and child development, child care, adoption, school selection and the college application and financial aid process.

Financial consultation

You may call the EAP for information, resources and to speak with a staff financial counselor on:

- General budget assistance
- Buying or leasing a car
- Planning for college or retirement

- Debt consolidation
- Savings and investments
- Tax assistance

Phone consultations are unlimited.

For more complex issues, the EAP provides for one free 30-minute initial office consultation with a local financial consultant per subject matter.

Legal consultation

The EAP provides one free initial office or telephone consultation with a network attorney per problem. If you need additional services, they are available with a 25% reduction from the provider's normal hourly rate. Legal assistance covers such topics as:

- Real estate matters
- Estate planning
- Family/divorce law
- Car accidents
- Criminal and government matters

This program does not include advice on issues regarding your program, its employees, providers or attorneys. It does not cover matters relating to your job or business concerns. This program does not provide advice on any matter that is frivolous, harassing or would otherwise be a violation of ethical rules.

Work/life resources

A full range of dependent care resources including child care and elder care referrals with verified openings, information about adoption assistance, parenting tips and information regarding educational options (financial assistance for college, etc.) are available to you.

If You Take an Approved Leave of Absence

Your EAP coverage may continue during an approved leave of absence as long as you continue to be employed by Starbucks.

When Coverage Ends

Your EAP benefit ends on the last day of the month in which your termination is processed by payroll.

How to File a Claim

There are no claims associated with the EAP services. However, there may be claims associated with treatment outside the scope of services covered through the EAP. Any costs incurred outside the EAP are not covered, and you are responsible for paying the provider directly. These costs may be covered by your mental health/chemical dependency benefits, if you are enrolled in a Starbucks medical plan administered by Premera. Refer to the When You Need Medical Care chapter for more information. If you are enrolled in HMSA, Kaiser California HMO or Kaiser Hawaii HMO, refer to your health provider's guide to benefits for information regarding mental health/chemical dependency benefits.

Questions?

The EAP is available to answer your questions 24 hours a day, seven days a week, at (800) 327-5564.

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Mildly Ill Child Care

When your child becomes ill and cannot attend school or day care, Starbucks will reimburse you 50% of the daily fee for Mildly Ill Child Care, up to a maximum of $30 per day, five days per plan year. All partners may participate in the Mildly Ill Child Care Program offered through the Starbucks EAP.

How the plan works

If you have children, it is a good idea to arrange for emergency back-up care in advance, before your child becomes ill. You may call the EAP at (800) 327-5564 to arrange a day care referral and register your child before a minor illness occurs. The EAP may help you find care in either a medically supervised center within a hospital or your home. Calling in advance to preregister your child increases your choices while saving you time. Or, if you want, you can arrange for emergency back-up care on your own at a facility or in your own home. Then, when your child gets sick, you simply call the day care provider directly to arrange care.

How to file a claim

When you receive Mildly Ill Child Care, you pay for services up front. Afterward, you may request reimbursement from Starbucks. To file a claim for Mildly Ill Child Care, take these steps:

- Obtain a Mildly Ill Child Care claim form from the EAP by calling (800) 327-5564, or link to the EAP website from www.mysbuxben.com.
- Complete the claim form and attach your child care provider receipt.
- Mail the form and receipt to Starbucks Benefits Department, Mail Stop S-HR3, P.O. Box 34067, Seattle, WA 98124-1067. Starbucks will mail your reimbursement.

Questions?

For answers to your questions about the Mildly Ill Child Care Program, or to receive information about arranging day care in advance, call the EAP directly at (800) 327-5564.

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Medical

Starbucks offers you a choice of medical plans depending on where you live. The plans vary in terms of where you can receive care, which medical expenses are covered, how much the plans cost you and where they are available. You decide which plan best meets your needs.

Starbucks medical plans are:

PLAN	AVAILABILITY	ADMINISTERED BY
Routine Care PPO	Available in all areas except Hawaii	Premera Blue Cross
Your Care PPO	Available in all areas except Hawaii	Premera Blue Cross
Kaiser California HMO	Available in California only	Kaiser Permanente
Kaiser Hawaii HMO	Available in Hawaii only	Kaiser Permanente
HMSA Preferred Provider Plan	Available in Hawaii only	HMSA

The Basics of Your Medical Plans

What you pay

You and Starbucks share the cost of medical benefits for you and your enrolled dependents. Your contributions for coverage are automatically deducted from your paycheck each pay period, as outlined in the Eligibility and Enrollment chapter.

In addition to these payroll deductions, you may have some out-of-pocket costs when you receive medical care. These costs include deductibles, copays and coinsurance.

What is a deductible?

A deductible is the amount you pay toward the cost of medical expenses before the plans begin paying benefits. Not all expenses are subject to the deductible and not all plans have a deductible. You may have an individual, per person deductible, or a family deductible that you pay for all of your covered family members combined. Some plans have a separate in-network and out-of-network deductible. In-network and out-of-network deductibles are not combined.

What is a copayment?

A copayment (copay for short) is the fixed amount you pay for a specific service before the plan begins to cover the costs of that service. For example, you pay $30 for an in-network doctor office visit with Your Care PPO Plus. The plan then covers 100% of remaining charges. Sometimes, both copayments and coinsurance apply.

What is coinsurance?

Coinsurance is the percentage of a health care cost you pay. For example, the Starbucks plan may cover 80% of an expense and you pay 20%. This 20% is your coinsurance.

What is a maximum lifetime benefit?

A maximum lifetime benefit is the most a medical plan will pay for an individual over his or her lifetime. The maximum lifetime benefit by plan is shown below:

PLAN	MAXIMUM LIFETIME BENEFIT
Premera plans combined	$2 million
HMSA Preferred Provider Plan	$1 million
Kaiser California HMO	Refer to your health provider's guide to benefits
Kaiser Hawaii HMO	Unlimited

The maximum benefit that will be paid by Starbucks medical plans administered by Premera Blue Cross combined over a lifetime is $2 million per covered person.

Each October 1, a portion of the benefits that have been paid for you or any of your enrolled dependents by Starbucks medical plans administered by Premera Blue Cross, combined during the previous plan year, will be reinstated. The maximum plan year reinstatement will be $10,000.

For example, if you had a serious illness and incurred $50,000 in expenses that were paid by your medical plan, up to $10,000 of those benefits would be reinstated the following October 1. This means that only the remaining $40,000 would count toward your lifetime maximum. Each subsequent plan year, up to another $10,000 can be reinstated.

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ID cards

When you enroll in a medical plan, an ID card will be mailed to your home. You need to present this card whenever you visit your doctor, medical facility or participating pharmacy for services.

If you do not receive an ID card within a month after enrolling or if you need additional or replacement ID cards, call or go online:

PLAN ADMINISTRATOR	PHONE NUMBER	AVAILABLE ONLINE AT THE MYSBUXBEN
Premera Blue Cross	(877) 728-9020	Link from www.mysbuxben.com
HMSA (Hawaii)	(877) 430-8092	
Kaiser California HMO	(800) 464-4000	
Kaiser Hawaii HMO	(800) 966-5955	

Review for medical necessity

Premera offers a voluntary benefit advisory process to determine the medical necessity of a proposed treatment. Certain procedures may be considered not medically necessary, experimental or investigational, have contract limitations, or contract exclusions – and will not be covered. A benefit advisory can help you avoid surprises. We encourage you to call Premera at (877) 728-9020 to determine if your procedure must be reviewed for medical necessity. If your procedure requires medical necessity review, you or your provider can fax information to (800) 843-1114.

Case Management

Premera Blue Cross Case Management works with you and your physician to consider effective alternatives to hospitalization and other high-cost care to make more efficient use of your Starbucks medical plan. Your participation in a treatment plan through Case Management is voluntary, but can help lower your costs. Contact Premera at (877) 728-9020 for more information.

If you take an approved leave of absence

Your medical coverage may continue during an approved leave of absence. See page 27 for more information. However, you will be required to continue to pay for your medical coverage during your leave. Contributions for medical coverage will be collected (depending on your length of leave) through either direct billing from Starbucks Benefits Center or retroactive payroll contributions upon your return to work. If you do not make your payments while on leave, your coverage may be cancelled. Call Starbucks Benefits Center at (877) SBUXBEN for more information.

When coverage ends

If you are no longer a Starbucks partner, your medical coverage ends on the last day of the month in which your termination is processed by payroll.

If you lose benefits eligibility due to the ongoing eligibility audit, your medical coverage ends as described in the Eligibility and Enrollment chapter.

You can elect to continue your coverage through COBRA as outlined in "Your COBRA Rights" on page 254.

Questions?

For answers to your questions about the medical plans or if this Benefits Plan Description or your health provider's guide to benefits does not contain complete information about the service or supply you need, call:

- Premera Blue Cross at (877) 728-9020
- HMSA at (877) 430-8092
- Kaiser California HMO at (800) 464-4000
- Kaiser Hawaii HMO at (800) 966-5955

About the Premera Blue Cross Medical Plans

This section includes important information about Starbucks medical plans administered by Premera: Your Care PPO and Routine Care PPO.

Plus and Standard versions

There are two versions of Your Care PPO and Routine Care PPO: Plus and Standard versions. If you take the HealthQuotient by your deadline (depending on whether you are enrolling as a new partner or during open enrollment in the summer), you will be enrolled in the Plus version of the medical plan you choose. You will also pay the lower rate for your coverage.

HealthQuotient is an online health assessment available at www.mysbuxben.com. It can help you identify your health risks and provides information and steps you can take to maintain or improve your health.

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Providers you can use

Under the Your Care PPO and Routine Care PPO, providers are defined as a health care practitioner or facility that is a licensed or certified provider category regulated by the state in which the practitioner or facility provides care, and that practices within the scope of such licensure or certification. Also included is an employee or agent of such practitioner or facility, acting in the course of and within the scope of his or her employment.

Health care facilities that are owned and operated by an agency of the U.S. government are included as required by federal law. Health care facilities owned by the political subdivision or instrumentality of a state are also covered.

- **Network providers:** Network providers are hospitals and other health care facilities, physicians and licensed professionals that participate in Premera's network. When you see a network provider, you will get the higher in-network level of benefits.
- **Out-of-network providers:** These providers and facilities are not part of the Premera network and they are only covered if you are in the Plus version of the plan. If you visit these providers for care, you will receive a significantly lower level of benefits under the Plus plans (and no coverage under the Standard plans). Consider your options carefully before using a non-network provider. Services provided by out-of-network providers for mental health care and chemical dependency treatment may not be covered depending on the plan you have selected.

Use network providers

Starbucks uses the Premera Blue Cross provider network and provider network arrangements with other Blue Cross and/or Blue Shield-contracted providers throughout the country. These networks consist of hospitals and other health care facilities, physicians and licensed professionals.

Make sure your medical provider is a part of the custom Premera network in order to receive the higher, in-network level of benefits. Use the Find a Doctor tool at www.mysbuxben.com to search for network providers, or contact Premera at (877) 728-9020. Not all Blue Cross and Blue Shield providers are part of the Premera network, so it is important to confirm whether or not your provider is included.

Participating pharmacies are also available nationwide. Please see the Prescription Drug chapter for more information.

Benefit level exceptions for non-emergency care

A "benefit level exception" is the plan's decision to provide in-network benefits for covered services from a non-network provider.

You, your provider, or the medical facility may ask Premera Blue Cross for a benefit level exception. However, the request must be made before you get the service or supply. If the request is approved, benefits for covered services and supplies will be provided at the in-network benefit level. Payment of your claim will be based on your eligibility and benefits available at the time you get the service or supply. You'll be responsible for amounts applied toward applicable deductibles, copays, coinsurance, amounts that exceed benefit maximums, amounts above allowable charges and charges for non-covered services. If the request is denied, in-network benefits will not be provided.

Contact Premera Partner Services at 877-728-9020 for more information or to apply.

Transferring your deductible between plans

If, during a plan year, you transfer between Your Care PPO and Routine Care PPO, any deductible satisfied under one plan may be applied to the deductible of the other plan.

Plan year out-of-pocket maximum

The plan year out-of-pocket maximum is the most you or your enrolled dependents must pay toward covered medical expenses in a plan year. The in-network and out-of-network plan year out-of-pocket maximums are separate and not combined. The following charges are not considered when calculating your out-of-pocket maximum:

- Deductible amounts
- All copays
- Amounts you pay for out-of-network prescriptions
- Charges in excess of allowed charges or a benefit maximum
- Charges for expenses not covered by the plan
- Expenses for nicotine-use treatment programs
- Expenses for temporomandibular joint disorder (TMJ)

	PLAN YEAR OUT-OF-POCKET MAXIMUM[1]	
Plan	**In-network**	**Out-of-network**
Your Care PPO Plus	$2,000 per person; $6,000 per family	$4,000 per person; $12,000 per family
Your Care PPO Standard	$4,000 per person; $12,000 per family	NA
Routine Care PPO Plus	$4,000 per person; $12,000 per family	$8,000 per person; $24,000 per family
Routine Care PPO Standard	$8,000 per person; $24,000 per family	NA

1: In-network and out-of-network out-of-pocket maximums are separate and cannot be combined.

Claims

When you visit a Premera network provider, claims will be handled by your provider and you will have no paperwork to complete. Premera will send you an Explanation of Benefits after the claim is processed that will tell you how much of the bill you owe. Or you can view your claim online at Premara Online. Link from www.mysbuxben.com.

When you visit an out-of-network provider, either you or your doctor must file a claim to receive benefits from the plan. For more information, see "How to File a Claim" on page 89.

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What is an allowable charge?

An allowable charge is the part of an out-of-network expense that is covered under your medical plan. All in-network care is within allowable charge guidelines. You're responsible only for applicable deductibles, coinsurance, and copays, if any, amounts in excess of stated benefit maximums and charges for non-covered services and supplies.

For out-of-network care, you are responsible for paying any amount that exceeds allowable charges. Amounts in excess of allowable charges do not count toward the plan year deductible, if any, or as coinsurance.

The allowable charge for a service or supply is the lower of:

- The provider's usual charge, or
- The charge your plan administrator determines to be appropriate for that service or supply, based on a national database.

When a service or supply is unusual, not often provided or provided by only a small number of providers in your area, your plan administrator will consider factors such as the complexity of the service or supply, degree of skill needed, provider specialty, range of services or supplies provided by a facility and recognized charges in other areas when determining the allowed charge.

About the Your Care PPO

The Your Care PPO offers you a choice of how you receive medical care:

- You can visit a provider or facility belonging to the Premera network.
- You can visit providers or facilities outside the network if you are in the Plus version of the plan.

The plan offers a higher level of coverage when you visit a network provider or a significantly lower level of coverage if you visit a non-network provider.

Your Care PPO coverage overview

Your Care PPO coverage information is shown on the following page. You are eligible for Your Care PPO Plus if you complete the HealthQuotient (HQ) by your enrollment deadline and annually thereafter during each year's benefits open enrollment. If you do not complete HQ, you are eligible for the Standard plan option only. For details on each of the services below, including coverage requirements, limitations and exclusions, refer to the specific medical service in the When You Need Medical Care chapter. For information on HQ, refer to the Eligibility and Enrollment chapter.

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MEDICAL SERVICE	YOUR CARE PPO PLUS (WHEN YOU TAKE HQ)		YOUR CARE PPO STANDARD (WITHOUT HQ)
	In-network	Out-of-network[1]	In-network only
Plan year deductible	$300 individual $900 family	$1,125 individual $3,375 family	$500 individual $1,500 family
Plan year out-of-pocket maximum	$2,000 individual $6,000 family	$4,000 individual $12,000 family	$4,000 individual $12,000 family
Physician services			
• Office visits including primary care, naturopath and specialist visits	You pay $30 copay, no deductible applies	You pay 60% after deductible	You pay 25% after deductible
• All other services	You pay 20% after deductible	You pay 60% after deductible	You pay 25% after deductible
Lab and imaging			
• Preventive lab, x-ray and cancer screening (includes preventive colon health and mammography)	Plan pays 100%	Not covered	You pay 25% after deductible
• All other services (includes diagnostic colon health and mammography)	You pay 20% after deductible	You pay 60% after deductible	You pay 25% after deductible
Preventive care			
• Well child visits, physical exams and routine wellness exams	Plan pays 100%; $500 maximum benefit per plan year	Not covered	You pay 25% after deductible; $500 maximum benefit per plan year
• Immunizations: *Zoster only covered for age 60+ (travel immunizations are not covered)*	Plan pays 100%	Not covered	You pay 25% after deductible
• Flu shots	You pay $10 copay, no deductible applies	Not covered	You pay 25% after deductible
Hospital inpatient	You pay 20% after deductible and $200 copay per admission	You pay 60% after deductible and $200 copay per admission	You pay 25% after deductible and $300 copay per admission
Hospital outpatient, surgery center outpatient and birthing centers	You pay 20% after deductible	You pay 60% after deductible	You pay 25% after deductible

1. Out-of-network reimbursement limited to allowable charges. You pay any amount in excess of allowable charges.

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MEDICAL SERVICE	YOUR CARE PPO PLUS (WHEN YOU TAKE HQ)		YOUR CARE PPO STANDARD (WITHOUT HQ)
	In-network	Out-of-network[1]	In-network only
Mental health and chemical dependency			
• Inpatient	You pay 20% after deductible and $200 copay per admission	You pay 60% after deductible and $200 copay per admission	You pay 25% after deductible and $300 copay per admission
• Outpatient	Covered as any other illness or injury, based on provider	You pay 60% after deductible	You pay 25% after deductible
Emergency care			
• Urgent care clinic	You pay 20% after a $50 copay, no deductible applies	You pay 20% after a $50 copay, no deductible applies	You pay 25% after a $50 copay, no deductible applies
• Hospital ER (no coverage if not an emergency); ER copay waived if admitted	You pay 20% after a $100 copay; deductible applies to physician services	You pay 20% after a $100 copay; deductible applies to physician services	You pay 25% after a $200 copay; deductible applies to physician services
• Ambulance transportation	You pay 20% after deductible	You pay 20% after deductible	You pay 25% after deductible
Hearing			
• Exams (one exam every 24 consecutive months)	100% after $30 copay	Not covered	Not covered
• Aids ($1,600 max every 36 consecutive months)	100%, no deductible applies	100%, no deductible	Not covered
Acupuncture			
• 12 visits per plan year	You pay $30 copay, no deductible applies	You pay 60% after deductible	Not covered
Chiropractic care			
• 15 visits per plan year (performed by a chiropractor)	You pay $30 copay, no deductible applies	You pay 60% after deductible	Not covered
Spinal and other manipulations (performed by any provider except a chiropractor)	You pay $30 copay, no deductible applies	You pay 60% after deductible	You pay 25% after deductible

1. Out-of-network reimbursement limited to allowable charges. You pay any amount in excess of allowable charges.

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MEDICAL SERVICE	YOUR CARE PPO PLUS (WHEN YOU TAKE HQ)		YOUR CARE PPO STANDARD (WITHOUT HQ)
	In-network	Out-of-network[1]	In-network only
Family planning, including contraceptive devices, sterilization			
• Vasectomy, tubal ligation, voluntary abortion, and other services	Covered as any other illness or injury, based on provider	You pay 60% after deductible	You pay 25% after deductible
Durable medical equipment	You pay 20% after deductible	You pay 60% after deductible	You pay 25% after deductible
Convalescent care (skilled nursing facility): up to 60 days per plan year	You pay 20% after deductible and $200 copay per admission	You pay 60% after deductible and $200 copay per admission	You pay 25% after deductible and $300 copay per admission
Special nursing care (private duty nursing): up to 70 shifts (560 hours) per plan year	You pay 20% after deductible	You pay 60% after deductible	You pay 25% after deductible
Home health care: up to 120 visits per plan year	You pay 20% after deductible	You pay 60% after deductible	You pay 25% after deductible
Hospice care: no limits **Hospice respite care:** 120 hours	Plan pays 100% after you pay deductible	You pay 60% after deductible	Plan pays 100% after you pay deductible
Inpatient rehabilitation: up to 30 days per plan year, all therapy combined	You pay 20% after deductible and $200 copay per admission	You pay 60% after deductible and $200 copay per admission	You pay 25% after deductible and $300 copay per admission
Outpatient rehabilitation: up to 60 visits per plan year, all therapy combined	You pay 20% after deductible	You pay 60% after deductible	You pay 25% after deductible
Neurodevelopmental therapy (includes autism)			
• Inpatient: up to 30 days per plan year - physical, speech and occupational therapy - children under age 7 only	You pay 20% after deductible and $200 copay per admission	You pay 60% after deductible and $200 copay per admission	You pay 25% after deductible and $300 copay per admission
• Outpatient: physical, speech and occupational therapy - children under age 7 only	You pay 20% after deductible	You pay 60% after deductible	You pay 25% after deductible
Nicotine-use treatment: $500 lifetime maximum	You pay $30 copay per office visit; plan pays 100% for other services, no deductible	You pay $30 copay per office visit; plan pays 100% for other services, no deductible	Not covered

1. Out-of-network reimbursement limited to allowable charges. You pay any amount in excess of allowable charges.

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MEDICAL SERVICE	YOUR CARE PPO PLUS (WHEN YOU TAKE HQ)		YOUR CARE PPO STANDARD (WITHOUT HQ)
	In-network	Out-of-network[1]	In-network only
Mouth, jaw, and teeth treatment	You pay $30 office visit copay; you pay 20% after deductible for other services	You pay 60% after deductible	You pay 25% after deductible
TMJ or MPD treatment: $3,000 lifetime maximum	You pay 50%, no deductible	You pay 60% after deductible	Not covered

1. Out-of-network reimbursement limited to allowable charges. You pay any amount in excess of allowable charges.

Remember, out-of-network coverage is only available through the Your Care PPO Plus plan option and is not available through the Standard plan option.

About the Routine Care PPO Plan

The Routine Care PPO offers you a choice of how you receive medical care:

- You can visit a provider or facility belonging to the Premera network.
- You can visit providers or facilities outside the network if you are in the Plus version of the plan.

The plan offers a higher level of coverage when you visit a network provider or a significantly lower level of coverage if you visit a non-network provider.

Routine Care PPO coverage overview

Routine Care PPO coverage information is shown below. You are eligible for Routine Care PPO Plus if you complete the HealthQuotient (HQ) by your enrollment deadline and annually thereafter during each year's benefits open enrollment. If you do not complete HQ, you are eligible for the Standard plan option only. For details on each of the services below, including coverage requirements, limitations and exclusions, refer to the specific medical service in the When You Need Medical Care chapter. For more information about HQ, refer to the Eligibility and Enrollment chapter.

MEDICAL SERVICE	ROUTINE CARE PPO PLUS (WHEN YOU TAKE HQ)		ROUTINE CARE PPO STANDARD (WITHOUT HQ)
	In-network	Out-of-network[1]	In-network only
Plan year deductible	$500 individual $1,500 family	$1,500 individual $4,500 family	$750 individual $2,250 family
Plan year out-of-pocket maximum	$4,000 individual $12,000 family	$8,000 individual $24,000 family	$8,000 individual $24,000 family

1. Out-of-network reimbursement limited to allowable charges. You pay any amount in excess of allowable charges.

MEDICAL SERVICE	ROUTINE CARE PPO PLUS (WHEN YOU TAKE HQ)		ROUTINE CARE PPO STANDARD (WITHOUT HQ)
	In-network	Out-of-network[1]	In-network only
Physician services			
• Office visits including primary care, naturopath and specialist visits	You pay 30%, no deductible applies	You pay 70% after deductible	You pay 35% after deductible
• All other services	You pay 30% after deductible	You pay 70% after deductible	You pay 35% after deductible
Lab and imaging			
• Preventive lab, x-ray and cancer screening (includes preventive colon health and mammography)	Plan pays 100%	Not covered	You pay 35% after deductible
• All other services (includes diagnostic colon health and mammography)	You pay 30% after deductible	You pay 70% after deductible	You pay 35% after deductible
Preventive care			
• Well child visits, physical exams and routine wellness exams	Plan pays 100%; $500 maximum benefit per plan year	Not covered	You pay 35% after deductible; $500 maximum benefit per plan year
• Immunizations: *Zoster only covered for age 60+ (travel immunizations are not covered)*	Plan pays 100%	Not covered	You pay 35% after deductible
• Flu shots	You pay $10 copay, no deductible applies	Not covered	You pay 35% after deductible
Hospital inpatient	You pay 30% after deductible and $400 copay per admission	You pay 70% after deductible and $400 copay per admission	You pay 35% after deductible and $500 copay per admission
Hospital outpatient, surgery center outpatient and birthing centers	You pay 30% after deductible	You pay 70% after deductible	You pay 35% after deductible
Mental health and chemical dependency			
• Inpatient	You pay 30% after deductible and $400 copay per admission	You pay 70% after deductible and $400 copay per admission	You pay 35% after deductible and $500 copay per admission
• Outpatient	Covered as any other illness or injury, based on provider	You pay 70% after deductible	You pay 35% after deductible

1. Out-of-network reimbursement limited to allowable charges. You pay any amount in excess of allowable charges.

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MEDICAL SERVICE	ROUTINE CARE PPO PLUS (WHEN YOU TAKE HQ)		ROUTINE CARE PPO STANDARD (WITHOUT HQ)
	In-network	Out-of-network[1]	In-network only
Emergency care			
• Urgent care clinic	You pay 30% after a $50 copay, no deductible applies	You pay 30% after a $50 copay, no deductible applies	You pay 35% after a $50 copay, no deductible applies
• Hospital ER (no coverage if not an emergency); ER copay waived if admitted	You pay 30% after a $100 copay; deductible applies to physician services	You pay 30% after a $100 copay; deductible applies to physician services	You pay 35% after a $200 copay; deductible applies to physician services
• Ambulance transportation	You pay 30% after deductible	You pay 30% after deductible	You pay 35% after deductible
Hearing			
• Exams	Not covered	Not covered	Not covered
• Aids	Not covered	Not covered	Not covered
Acupuncture	Not covered	Not covered	Not covered
Chiropractic care	Not covered	Not covered	Not covered
Spinal and other manipulations (performed by any provider except a chiropractor)	You pay 30%, no deductible applies	You pay 70% after deductible	You pay 35% after deductible
Family planning, including contraceptive devices, sterilization			
• Vasectomy, tubal ligation, voluntary abortion, and other services	Covered as any other illness or injury, based on provider	You pay 70% after deductible	You pay 35% after deductible
Durable medical equipment	You pay 30% after deductible	You pay 70% after deductible	You pay 35% after deductible
Convalescent care (skilled nursing facility): up to 60 days per plan year	You pay 30% after deductible and $400 copay per admission	You pay 70% after deductible and $400 copay per admission	You pay 35% after deductible and $500 copay per admission
Special nursing care (private duty nursing): up to 70 shifts (560 hours) per plan year	You pay 30% after deductible	You pay 70% after deductible	You pay 35% after deductible
Home health care: up to 120 visits per plan year	You pay 30% after deductible	You pay 70% after deductible	You pay 35% after deductible
Hospice care: no limits **Hospice respite care:** 120 hours	Plan pays 100% after deductible	You pay 70% after deductible	Plan pays 100% after deductible

1. Out-of-network reimbursement limited to allowable charges. You pay any amount in excess of allowable charges.

MEDICAL SERVICE	ROUTINE CARE PPO PLUS (WHEN YOU TAKE HQ)		ROUTINE CARE PPO STANDARD (WITHOUT HQ)
	In-network	Out-of-network[1]	In-network only
Inpatient rehabilitation: up to 30 days per plan year, all therapy combined	You pay 30% after deductible and $400 copay per admission	You pay 70% after deductible and $400 copay per admission	You pay 35% after deductible and $500 copay per admission
Outpatient rehabilitation: up to 60 visits per plan year, all therapy combined	You pay 30% after deductible	You pay 70% after deductible	You pay 35% after deductible
Neurodevelopmental therapy (includes autism)			
• Inpatient: up to 30 days per plan year - physical, speech and occupational therapy - children under age 7 only	You pay 30% after deductible and $400 copay per admission	You pay 70% after deductible and $400 copay per admission	You pay 35% after deductible and $500 copay per admission
• Outpatient: physical, speech and occupational therapy - children under age 7 only	You pay 30% after deductible	You pay 70% after deductible	You pay 35% after deductible
Nicotine-use treatment: $500 lifetime maximum	You pay 30% per office visit, no deductible; plan pays 100% for other services, no deductible	You pay 30% per office visit, no deductible; plan pays 100% for other services, no deductible	Not covered
Mouth, jaw, and teeth treatment	You pay 30% per office visit, no deductible; you pay 30% after deductible for other services	You pay 70% after deductible	You pay 35% after deductible
TMJ or MPD treatment: $3,000 lifetime maximum	You pay 50%, no deductible	You pay 70% after deductible	Not covered

1. Out-of-network reimbursement limited to allowable charges. You pay any amount in excess of allowable charges.

Remember, out-of-network coverage is only available through the Routine Care PPO Plus plan option and is not available through the Standard plan option.

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Overview of Other Medical Plans

About the HMSA Preferred Provider Plan

The HMSA Preferred Provider Plan is available to eligible partners in Hawaii. The plan offers a choice of receiving care in- or out-of-network. When you use HMSA network providers, however, your costs are lower.

You do not pay a deductible for most in-network services. Routine physicals are covered at 100%, up to plan limits. And you just pay a copay for most prescription drugs.

For detailed information about the HMSA Preferred Provider Plan, please refer to HMSA Preferred Provider Plan Guide to Benefits, available from Starbucks Benefits Center at (877) SBUXBEN. The HMSA Preferred Provider Plan Guide to Benefits is considered a component of the contract and will be used as the source document when processing claims.

Providers you can use

You can see any licensed provider and be covered. When you use HMSA providers, more of your costs are covered and the deductible does not apply. For example, the plan covers 90% of the cost of a doctor office visit from a network provider. If you use a provider not in the network, the plan covers 70% of the cost after you meet the $100 deductible for single coverage, or $300 for family coverage.

You can find a list of participating providers online at www.mysbuxben.com and link to the Health Plans page. You can also request a printed copy of an HMSA provider directory by calling HMSA directly at (808) 948-6111.

Covered medical services

The plan covers a wide range of services, including doctor office visits, preventive care, hospitalization, emergency care and prescription drugs.

Brochures and enrollment information outlining details of the HMSA Preferred Provider Plan are available upon request at no cost to you. Contact Starbucks Benefits Center at (877) SBUXBEN. The brochures and enrollment materials describe:

- The nature of services provided
- Conditions of eligibility for services
- Circumstances under which services may be denied
- Procedures to obtain services
- Procedures for review of claims for services that have been denied either totally or in part

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About the Kaiser California HMO Plan

The Kaiser California HMO Plan is available to eligible partners and their dependents working in California (except for certain areas as determined by Kaiser Permanente). The plan covers medically necessary services within the California service area at Kaiser Permanente facilities. To be covered, your care must be provided and arranged by a Kaiser Permanente physician.

For detailed information, please refer to the Kaiser California HMO Plan Evidence of Coverage and Disclosure Form Parts One and Two. It is available by calling Starbucks Benefits Center at (877) SBUXBEN or online at www.mysbuxben.com and link to the Forms/Resources page.

Receiving care

You'll need to present your Kaiser Permanente ID card to receive care and services. Please carry it with you at all times.

We encourage you to choose your own Kaiser Permanente personal physician, who will provide and coordinate the medical services you need. This allows for greater continuity of care and provides you the opportunity to choose someone with whom you feel comfortable. You can choose a personal physician who practices in internal medicine, family medicine, pediatrics and, for women, obstetrics/gynecology. You also have the freedom to change your personal physician for any reason.

In many cases, you'll need a referral to see a specialist for the first time. Your personal physician can refer you to a specialist when it's medically necessary.

For more information about your Kaiser Permanente ID card, selecting a personal physician, and for a list of services and departments, visit www.mysbuxben.com and link to Kaiser Permanente California HMO.

Covered medical services

Generally, all care must be provided by Kaiser Permanente providers and facilities to be covered. Evidence of Coverage brochures and enrollment information outlining details of the Kaiser Permanente California HMO Plan are available upon request at no cost to you. Contact Starbucks Benefits Center at (877) SBUXBEN.

The brochures and enrollment materials describe:

- The nature of services provided
- Conditions of eligibility for services
- Circumstances under which services may be denied
- Procedures to obtain services
- Procedures for review of claims for services that have been denied either totally or in part

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About the Kaiser Hawaii HMO Plan

The Kaiser Hawaii HMO Plan is available to eligible partners and their dependents working in the Hawaii service area of Oahu, Maui, Kauai and Hawaii (except for certain areas as determined by Kaiser Permanente). The plan covers medically necessary services within the Hawaii service area at Kaiser Permanente facilities. To be covered, your care must be provided and arranged by a Kaiser Permanente physician.

For detailed information, please refer to the Kaiser Hawaii HMO Plan Group Medical and Hospital Service Agreement, available from the Starbucks Benefits Center at (877) SBUXBEN. The Group Medical and Hospital Service Agreement is considered a component of the contract and will be used as the source document when processing claims.

Receiving care

You'll need to present your Kaiser Permanente ID card to receive care and services. Please carry it with you at all times.

We encourage you to choose your own Kaiser Permanente primary care physician (PCP), who will provide and coordinate all the medical services you need. This allows for greater continuity of care and provides you the opportunity to choose someone with whom you feel comfortable. You also have the freedom to change your PCP at any time.

You'll need a referral to see a specialist for the first time. Your PCP can refer you to a specialist when it's medically necessary.

For more information about your Kaiser Permanente ID card, selecting a PCP, and for a list of services and departments you can self-refer to, visit www.mysbuxben.com and link to Hawaii Medical Plans.

Covered medical services

Generally, all care must be provided by Kaiser Permanente providers and facilities to be covered. Brochures and enrollment information outlining details of the Kaiser Hawaii HMO Plan are available upon request at no cost to you. Contact Starbucks Benefits Center at (877) SBUXBEN.

The brochures and enrollment materials describe:

- The nature of services provided
- Conditions of eligibility for services
- Circumstances under which services may be denied
- Procedures to obtain services
- Procedures for review of claims for services that have been denied either totally or in part

When You Need Medical Care

In this section, you can find information, arranged alphabetically, about Starbucks medical plan coverage administered by Premera, including what services and supplies are and are not covered. For information on how the plans cover your costs, please see the Medical chapter.

Acupuncture

Acupuncture is covered under the Your Care PPO Plus plan only. Acupuncture is not covered under the Your Care PPO Standard or Routine Care PPO plans.

Benefits are provided for acupuncture services when medically necessary to relieve pain, induce surgical anesthesia or to treat a covered illness, injury or condition. Benefits are provided for up to 12 visits per member per plan year.

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Benefit Advisory

Premera offers a voluntary benefit advisory process to determine the medical necessity of a proposed treatment. Certain procedures may be considered not medically necessary, experimental or investigational, have contract limitations, or contract exclusions - and will not be covered. A benefit advisory can help you avoid surprises. You are encouraged to call Premera at (877) 728-9020 to determine if your procedure must be reviewed for medical necessity. If your procedure requires a medical necessity review, you or your provider can fax information to (800) 843-1114.

Chemical Dependency Treatment

You are covered for medically necessary chemical dependency treatment as long as you remain enrolled in a Starbucks medical plan administered by Premera Blue Cross. Benefits are provided for inpatient and outpatient chemical dependency treatment, detoxification and other supporting services. Covered services must be furnished by a state-approved treatment program.

Chemical dependency is an illness characterized by physiological or psychological dependency, or both, on a controlled substance regulated under Chapter 69.50 RCW and/or alcoholic beverages. It's further characterized by a frequent or intense pattern of pathological use to the extent:

- The user exhibits a loss of self-control over the amount and circumstances of use.
- The user develops symptoms of tolerance, or psychological and/or physiological withdrawal if use of the controlled substance or alcoholic beverage is reduced or discontinued.
- The user's health is substantially impaired or endangered, or his or her social or economic function is substantially disrupted.

What the plans cover

Covered chemical dependency treatment includes:

- Inpatient hospitalization
- Partial hospitalization

- Intensive outpatient treatment
- Residential treatment
- Outpatient care

Inpatient

Covered expenses for treatment in a hospital or treatment facility include:

- Treatment of the medical complications of alcoholism or drug abuse
- Treatment of alcoholism or drug abuse
- Room and board
- Other medically necessary services and supplies

Partial hospitalization, intensive outpatient care and residential treatment

When you require care that is more intensive than outpatient visits but not as acute as inpatient hospitalization, the plan covers alternative levels of care, including partial hospitalization, intensive outpatient care and residential treatment.

Partial hospitalization refers to hospital or hospital-like services provided, generally 6 to 8 hours a day and 5 to 7 days per week. The patient returns home each evening.

Intensive outpatient care refers to care delivered on an outpatient basis, generally in a hospital or other facility setting, usually more than two times per week. Care is generally provided in a structured group format.

Residential treatment refers to 24-hour-a-day sub-acute care, supervision and support in a licensed residential facility under the supervision of licensed or certified mental health professionals.

Outpatient

Generally, outpatient care is individual or group counseling. The Premera Blue Cross network has a full range of providers, including hospitals, outpatient centers, residential treatment centers, clinics, psychiatrists, psychologists, clinical social workers and other behavioral health care providers.

You can obtain a list of network providers by linking to Premera's online provider directory from www.mysbuxben.com or by calling Premera at (877) 728-9020.

What is not covered

- Voluntary support groups, such as Alanon or Alcoholics Anonymous
- Court-ordered services, services related to deferred prosecution, deferred or suspended sentencing, or to driving rights, except as deemed medically necessary
- Family and marital counseling, and family and marital psychotherapy, as distinct from counseling, except when medically necessary to treat the diagnosed substance-use disorder or disorders of a member
- Services, treatments or supplies primarily for rest, custodial, domiciliary or convalescent care